Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

The Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747
Boston, Massachusetts 02114-8747

(617) 727-2310
Fax (617) 227-2681
TTY (617) 227-8583
www.mass.gov/gic

Original _____

Renewal _____

Dear Insured:

We have received the request for your dependent's handicapped dependent coverage.

Please note that in order for a dependent to apply for handicapped dependent coverage, he or she must meet one of the following conditions:

- became mentally or physically incapable of earning his/her own living prior to age 19; or
- became permanently and totally disabled and became so on or after age 19 and is under age 26.

If your dependent meets one of these two requirements, we have listed below information for you to return to the GIC so that a decision can be made on your application. If your dependent is working, please include a copy of his/her latest earnings statement.

INFORMATION FROM THE INSURED PARENT

The insured parent must complete the "*Statement From Insured Parent For Handicapped Dependent Coverage"* (page 1 of 2). Please answer all questions completely so that we can process your application as quickly as possible.

INFORMATION FROM THE DEPENDENT'S PERSONAL PHYSICIAN

Please have the Physician's Statement (page 2 of 2) completed by the dependent's personal physician; the physician must be licensed to practice medicine in Massachusetts or the state in which you reside.

Please return the entire completed application to us (no fax transmittals or photocopies accepted). We shall try to have a response to you within four to six weeks of receiving your completed application. If you have any questions concerning this application, contact us at (617) 727-2310, extension 5.

Sincerely,
Continued Coverage Unit
Group Insurance Commission

STATEMENT FROM INSURED PARENT FOR HANDICAPPED DEPENDENT COVERAGE

This form will be returned if it is not fully completed.

FuII Name of Dependent _____

Dependent's Date of Birth _____ Dependent's Soc. Sec. Number _____

Dependent's Address _____

City _____ State _____ Zip Code _____

Dependent's Marital Status _____

Full Name of Insured _____

Insured's Address _____

City _____ State _____ Zip Code _____

Insured's Social Security Number _____

Date Dependent Became Totally Disabled _____

Is your dependent working? Yes ___ No ___

Is yes, indicate name of employer _____

Indicate annual salary _____

If the dependent is over age 19, have they had health insurance coverage from age 19 to the present?

YES _____ No _____

If *YES,* please provide the following:

Name of Insurance Carrier _____

Name of Employer _____

The effective date of coverage _____

Is coverage still in effect? Yes _____ No _____

If No, when was coverage cancelled and why? _____

If No, please provide the following:

Is your dependent eligible for Medicare Benefits? Yes ____ No ___ Never Applied for Medicare _____

If YES, please include a photocopy of the Medicare Claim Card

If NO, please include a letter from your local Social Security Office advising of the reason the dependent is not eligible for Medicare benefits.

Please read and sign the following statement and if the dependent is capable, please also have the dependent sign.

I hereby apply for handicapped dependent coverage and agree to periodic independent physician examinations as requested by the GIC. I hereby certify under the pains and penalties of perjury that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies and financial consequences, at the GIC's discretion.

Signature of Insured Parent _____ Date _____

Signature of Dependent _____ Date _____

PHYSICIAN'S STATEMENT FROM ATTENDING PHYSICIAN

Note: this form will be returned if not fully completed.

Insured Parent's Name _____

Name of Patient _____

Patient's diagnosis and date of illness _____

(a) Is the patient currently working? YES _____ NO _____

(b) Is the patient currently capable of self support YES _____ NO _____

(c) If NO to question b is there any potential that the patient will eventually be capable of self-support?

YES _____ NO _____

(d) If YES to question c, please provide your best estimate of when the patient will be capable of self-support. _____

Date of onset of disability (the inability to support themselves). _____

How long have you been treating this patient for the diagnosis indicated above? State other diagnosis if necessary.

Include first and most recent visits. _____

_____

_____

_____

Describe your treatment plan including a prognosis and goals for this patient in as much detail as possible and, if the patient is enrolled in a vocational training, rehabilitation or similar program, include goals and timetables that have been established for the program. (Attach other sheets as necessary.)

_____

_____

_____

_____

Under the pains and penalties of perjury, I attest that all statements I have made on this form are true.

Physician's Signature _____ Date _____

Physician's Data (please print or type the following information): _____

Name _____ Specialty _____

Address _____ City _____ State _____ Zip Code _____

Telephone No (_____) _____

Insured: Mail pages 1 and 2 of this form to the GIC at the address below. Keep a copy for your records.

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